General Assembly

Raised Bill No. 5011

February Session, 2012

LCO No. **316**

00316_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT CONCERNING THE LEGISLATIVE COMMISSIONERS' RECOMMENDATIONS FOR TECHNICAL AND MINOR CHANGES TO THE INSURANCE STATUTES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsections (b) and (c) of section 38a-15 of the 2012 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) To carry out the examinations under this section, the commissioner may appoint, as market conduct examiners, one or more competent persons, not officers or connected with or interested in any insurance company, health care center or fraternal benefit society, other than as a policyholder. In conducting the examination, the commissioner, **[**his**]** the commissioner's actuary or any examiner authorized by the commissioner may examine, under oath, the officers and agents of such an insurance company, health care center or fraternal benefit society and all persons deemed to have material information regarding the company's, center's or society's property or business. Each such company, center or society, its officers and agents, shall produce the books and papers, in its or their possession, relating

to its business or affairs, and any other person may be required to produce any book or paper, in his custody, deemed to be relevant to the examination, for the inspection of the commissioner, his actuary or examiners, when required. The officers and agents of the company, center or association shall facilitate the examination and aid the examiners in making the same so far as it is in their power to do so.

(c) Each market conduct examiner shall make a full and true report of each market conduct examination made by **[**him**]** such examiner, which shall comprise only facts appearing upon the books, papers, records or documents of the examined company, center or society or ascertained from the sworn testimony of its officers or agents or of other persons examined under oath concerning its affairs. The examiner's report shall be presumptive evidence of the facts therein stated in any action or proceeding in the name of the state against the company, center or society, its officers or agents. The commissioner shall grant a hearing to the company, center or society examined, before filing any such report, and may withhold any such report from public inspection for such time as **[**he**]** the commissioner deems proper. The commissioner may, if he deems it in the public interest, publish any such report, or the result of any such examination contained therein, in one or more newspapers of the state.

Sec. 2. Subdivision (5) of subsection (a) of section 38a-91bb of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(5) No captive insurance company may provide private passenger motor vehicle or **[**homeowner's**]** homeowners insurance coverage or any component thereof;

Sec. 3. Subsection (g) of section 38a-155 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(g) All insurance products sold through the insurance companies

authorized by this section and the insurance company authorized by section 4 of public act 84-323 shall be available to be sold by any licensed independent agent, as provided in sections 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to 38a-745, inclusive, as amended by this act, 38a-769 to **[**38a-777**]** 38a-776, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794 and so authorized by such insurance company.

Sec. 4. Section 38a-188 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Each health care center governed by sections 38a-175 to 38a-192, inclusive, shall be exempt from the provisions of the general statutes relating to insurance in the conduct of its operations under said sections and in such other activities as do constitute the business of insurance, unless expressly included therein, and except for the following: Sections 38a-11, 38a-17, 38a-51, 38a-52, 38a-56, 38a-57, 38a-129 to 38a-140, inclusive, 38a-147 and 38a-815 to 38a-819, inclusive, provided a health care center shall not be deemed in violation of sections 38a-815 to 38a-819, inclusive, solely by virtue of such center selectively contracting with certain providers in one or more specialties, and sections 38a-80, 38a-492b, 38a-518b, 38a-543, 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to 38a-745, inclusive, as amended by this act, 38a-769, 38a-770, as amended by this act, 38a-772 to **[**38a-777**]** 38a-776, inclusive, as amended by this act, 38a-786, 38a-790, 38a-792 and 38a-794, provided a health care center organized as a nonprofit, nonstock corporation shall be exempt from sections 38a-146, 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to 38a-745, inclusive, as amended by this act, 38a-769, 38a-770, as amended by this act, 38a-772 to **[**38a-777**]** 38a-776, inclusive, as amended by this act, 38a-786, 38a-790, 38a-792 and 38a-794. If a health care center is operated as a line of business, the foregoing provisions shall, where possible, be applied only to that line of business and not to the organization as a whole. The commissioner may adopt regulations, in accordance with chapter 54,

stating the circumstances under which the resources of a person which controls a health care center, or operates a health care center as a line of business will be considered in evaluating the financial condition of a health care center. Such regulations, if adopted, shall require as a condition to the consideration of the resources of such person which controls a health care center, or operates a health care center as a line of business to provide satisfactory assurances to the commissioner that such person will assume the financial obligations of the health care center. During the period prior to the effective date of regulations issued under this section, the commissioner shall, upon request, consider the resources of a person which controls a health care center, or operates a health care center as a line of business, if the commissioner receives satisfactory assurances from such person that it will assume the financial obligations of the health care center and determines that such person meets such other requirements as the commissioner determines are necessary. A health care center organized as a nonprofit, nonstock corporation shall be exempt from the sales and use tax and all property of each such corporation shall be exempt from state, district and municipal taxes. Each corporation governed by sections 38a-175 to 38a-192, inclusive, shall be subject to the provisions of sections 38a-903 to 38a-961, inclusive. Nothing in this section shall be construed to override contractual and delivery system arrangements governing a health care center's provider relationships.

Sec. 5. Subsection (b) of section 38a-271 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) The provisions of sections 38a-271 to 38a-278, inclusive, <u>as amended by this act,</u> other than section 38a-277, do not apply to: (1) The lawful transaction of surplus lines insurance; (2) the lawful transaction of reinsurance by insurers; (3) transactions, in this state, involving a policy lawfully solicited, written and delivered outside of this state covering only subjects of insurance not resident, located or expressly to be performed in this state at the time of issuance, and

which transactions are subsequent to the issuance of such policy; (4) transactions involving contracts of insurance independently procured pursuant to the unsolicited application of the insured or his or her agent which are reported and on which a premium tax is paid in accordance with section 38a-277; (5) attorneys acting in the ordinary relation of attorney-client in the adjustment of claims or losses; (6) transactions, in this state, involving contracts of insurance issued to one or more industrial insureds, provided nothing in this section shall relieve an industrial insured from the taxation imposed upon independently procured insurance in section 38a-277. For the purpose of this subdivision, an "industrial insured" shall mean an insured **[**(i)**]** (A) which procures the insurance of any risk by the use of the services of a full-time employee acting as an insurance manager or buyer, or the services of a regularly and continuously retained qualified insurance consultant, and **[**(ii)**]** (B) whose aggregate annual premiums for insurance, excluding life, accident and health insurance, total at least fifty thousand dollars; (7) transactions involving contracts issued by a life insurance or annuity company, organized and operated without profit, to any private shareholder or individual exclusively for the purpose of aiding and strengthening educational institutions or charitable, health and welfare organizations by issuing insurance and annuity contracts only to or for the benefit of such institutions or organizations and individuals engaged in the service of such institutions or organizations; (8) transactions in this state involving group life and group sickness and accident or franchise sickness and accident insurance or group annuities where the master policy of such groups was lawfully issued and delivered in and pursuant to the laws of a state in which the insurer was authorized to do an insurance business to a group organized for purposes other than the procurement of insurance, and where the policyholder is domiciled or otherwise has a bona fide situs; (9) transactions in this state involving any policy of insurance or annuity contract issued prior to January 1, 1970.

Sec. 6. Subsection (f) of section 38a-323 of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective from passage*):

(f) (1) No surplus lines insurer shall be deemed eligible to write coverage for risks as provided in sections 38a-741 to 38a-744, inclusive, as amended by this act, **[**38a-777,**]** and 38a-794, unless such surplus lines insurer complies with the requirements of this section. (2) Notwithstanding the provisions of subsection (b) of this section, premium billing notices shall be provided by any surplus lines insurer to the insured at least sixty days in advance of the renewal or anniversary date of the policy. Notices of nonrenewal or premium billing required by this section shall be provided by the surplus lines insurer or its duly authorized representative to the insured. (3) Notwithstanding the provisions of subsection (c) of this section, failure of any surplus lines insurer to provide the insured with the required notice of nonrenewal or premium billing shall entitle the insured to an extension of the policy for a period of ninety days after the renewal or anniversary date of such policy, provided if the surplus lines insurer fails to provide the required notice on or before the renewal or anniversary date of such policy, the provisions of subsection (c) of this section shall apply. In the event of such a ninety-day extension of coverage, the premium for the extended period of coverage shall be the current rate or the previous rate, whichever is lower.

Sec. 7. Subsection (b) of section 38a-324 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) No surplus lines insurer shall be deemed to be eligible to write coverage for risks as provided in sections 38a-741 to 38a-744, inclusive, as amended by this act, **[**38a-777**]** and 38a-794, unless such insurer complies with the requirements of subsection (a) of this section.

Sec. 8. Subsection (b) of section 38a-364 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) Each insurance company that issues private passenger motor vehicle liability insurance providing the security required by sections 38a-19 and 38a-363 to 38a-388, inclusive, shall issue annually to each such insured an automobile insurance identification card, in duplicate, for each insured vehicle, one of which shall be presented to the commissioner as provided in section 14-12b and the other carried in the vehicle as provided in section **[**14-12f**]** 14-13. Except as provided in subsection (c) of this section, such card shall be effective for a period of one year and shall include the name of the insured and insurer, the policy number, the effective date of coverage, the year, make or model and vehicle identification number of the insured vehicle and an appropriate space wherein the insured may set forth the year, make or model and vehicle identification number of any private passenger motor vehicle that becomes covered as a result of a change in the covered vehicle during the effective period of the identification card. When an insured has five or more private passenger motor vehicles registered in this state, the insurer may use the designation "all owned vehicles" on each card in lieu of a specific vehicle description. Each insurance company that delivers, issues for delivery or renews such private passenger motor vehicle liability insurance in this state **[**on or after January 1, 2009,**]** shall include on such card, the following notice, printed in capital letters and boldface type:

NOTICE:

YOU HAVE THE RIGHT TO CHOOSE THE LICENSED REPAIR SHOP WHERE THE DAMAGE TO YOUR MOTOR VEHICLE WILL BE REPAIRED.

Sec. 9. Subsection (a) of section 38a-472h of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) No insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing an

individual or group dental plan in this state shall include in any contract with a dentist licensed pursuant to chapter 379 that is entered into, renewed or amended on or after January 1, 2012, **[**shall contain**]** any provision that requires such dentist to accept as payment an amount set by such insurer, center, society, corporation or entity for services or procedures provided to an insured or enrollee that are not covered benefits under such insured's or enrollee's plan.

Sec. 10. Subdivision (3) of subsection (b) of section 38a-478g of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(3) A description of emergency services, the appropriate use of emergency services, including **[**to**]** the use of E 9-1-1 telephone systems, any cost sharing applicable to emergency services and the location of emergency departments and other settings in which participating physicians and hospitals provide emergency services and post stabilization care;

Sec. 11. Subsection (d) of section 38a-481 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) Rates on a particular policy form **[**will**]** shall not be deemed excessive if the insurer has filed a loss ratio guarantee with the Insurance Commissioner which meets the requirements of subsection (e) of this section provided (1) the form of such loss ratio guarantee has been explicitly approved by the Insurance Commissioner, and (2) the current expected lifetime loss ratio is not more than five per cent less than the filed lifetime loss ratio as certified by an actuary. The insurer shall withdraw the policy form if the commissioner determines that the lifetime loss ratio will not be met. Rates also will not be deemed excessive if the insurer complies with the terms of the loss ratio guarantee. The Insurance Commissioner may adopt regulations, in accordance with chapter 54, to assure that the use of a loss ratio guarantee does not constitute an unfair practice.

Sec. 12. Subsection (a) of section 38a-490 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Each individual health insurance policy delivered, issued for delivery, renewed, amended or continued in this state providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 for a family member of the insured or subscriber shall, as to such family **[**members'**]** member's coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

Sec. 13. Subsection (a) of section 38a-516 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Each group health insurance policy delivered, issued for delivery, renewed, amended or continued in this state providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 for a family member of the insured or subscriber shall, as to such family **[**members'**]** member's coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

Sec. 14. Section 38a-495c of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity in this state **[**, on or after January 1, 1994, which**]** that delivers, issues for delivery, continues or renews any Medicare supplement insurance policies or certificates shall base the premium rates charged on a community rate. Such rate shall not be based on

age, gender, previous claims history or the medical condition of the person covered by such policy or certificate. Except as provided in subsection (c) of this section, coverage shall not be denied on the basis of age, gender, previous claim history or the medical condition of the person covered by such policy or certificate.

(b) Nothing in this section shall prohibit an insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity in this state issuing Medicare supplement insurance policies or certificates from using its usual and customary underwriting procedures, provided no such company, society, corporation, center or other entity shall issue a Medicare supplement policy or certificate based on the age, gender, previous claims history or the medical condition of the applicant.

(c) Nothing in this section shall prohibit an insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity in this state when granting coverage under a Medicare supplement policy or certificate from excluding benefits for losses incurred within six months from the effective date of coverage based on a preexisting condition, in accordance with section 38a-495a and the regulations adopted pursuant to section 38a-495a.

(d) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity in the state issuing Medicare supplement policies or certificates for plan "A", "B" or "C", or any combination thereof, to persons eligible for Medicare by reason of age, shall offer for sale the same such policies or certificates to persons eligible for Medicare by reason of disability.

(e) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity in the state issuing Medicare supplement policies or certificates shall make all necessary arrangements with the Medicare

Part B carrier and all Medicare Part A intermediaries to allow for the forwarding, to the issuing entity, of all Medicare claims containing the name of the entity issuing a Medicare supplement policy or certificate and the identification number of an insured. The entity issuing the Medicare supplement policy or certificate shall process all benefits available to an insured from a Medicare claim so forwarded, without requiring any additional action on the part of the insured.

[(f) The provisions of this section shall apply to all Medicare supplement policies or certificates issued on and after January 1, 1994. For Medicare supplement policies or certificates issued prior to January 1, 1994, the provisions of this section shall apply as of the first rating period commencing on or after January 1, 1994, but no later than January 1, 1995.**]**

[(g)**]** (f) The Insurance Commissioner may adopt regulations, in accordance with chapter 54, to implement this section.

Sec. 15. Section 38a-501 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) (1) As used in this section, "long-term care policy" means any individual health insurance policy **[**,**]** delivered or issued for delivery to any resident of this state on or after July 1, 1986, **[**which**]** that is designed to provide, within the terms and conditions of the policy, benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for at least one year after an elimination period (A) not to exceed one hundred days of confinement, or (B) of over one hundred days but not to exceed two years of confinement, provided such period is covered by an irrevocable trust in an amount estimated to be sufficient to furnish coverage to the grantor of the trust for the duration of the elimination period. Such trust shall create an unconditional duty to pay the full amount held in trust exclusively to cover the costs of confinement during the

elimination period, subject only to taxes and any trustee's charges allowed by law. Payment shall be made directly to the provider. The duty of the trustee may be enforced by the state, the grantor or any person acting on behalf of the grantor. A long-term care policy shall provide benefits for confinement in a nursing home or confinement in the insured's own home or both. Any additional benefits provided shall be related to long-term treatment of an injury, illness or loss of functional capacity. "Long-term care policy" shall not include any such policy **[**which**]** that is offered primarily to provide basic Medicare supplement coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage or limited benefit health coverage.

(2) (A) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any long-term care policy in this state may refuse to accept or make reimbursement pursuant to a claim for benefits submitted by or prepared with the assistance of a managed residential community, as defined in section 19a-693, in accordance with subdivision (7) of subsection (a) of section 19a-694 solely because such claim for benefits was submitted by or prepared with the assistance of a managed residential community.

(B) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any long-term care policy in this state shall, upon receipt of a written authorization executed by the insured, (i) disclose information to a managed residential community for the purpose of determining such insured's eligibility for an insurance benefit or payment, and (ii) provide a copy of the initial acceptance or declination of a claim for benefits to the managed residential community at the same time such

acceptance or declination is made to the insured.

(b) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center may deliver or issue for delivery any long-term care policy **[**which**]** that has a loss ratio of less than sixty per cent for any individual long-term care policy. An issuer shall not use or change premium rates for a long-term care insurance policy unless the rates have been filed with and approved by the Insurance Commissioner. Any rate filings or rate revisions shall demonstrate that anticipated claims in relation to premiums when combined with actual experience to date can be expected to comply with the loss ratio requirement of this section. A rate filing shall include the factors and methodology used to estimate irrevocable trust values if the policy includes an option for the elimination period specified in subdivision **[**(2)**]** (1) of subsection (a) of this section.

(c) No such company, society, corporation or center may deliver or issue for delivery any long-term care policy without providing, at the time of solicitation or application for purchase or sale of such coverage, full and fair disclosure of the benefits and limitations of the policy. If the offering for any long-term care policy includes an option for the elimination period specified in subdivision **[**(2)**]** (1) of subsection (a) of this section, the application form for such policy and the face page of such policy shall contain a clear and conspicuous disclosure that the irrevocable trust may not be sufficient to cover all costs during the elimination period.

(d) No such company, society, corporation or center may deliver or issue for delivery any long-term care policy on or after July 1, 2008, without offering, at the time of solicitation or application for purchase or sale of such coverage, an option to purchase a policy that includes a nonforfeiture benefit. Such offer of a nonforfeiture benefit may be in the form of a rider attached to such policy. In the event the nonforfeiture benefit is declined, such company, society, corporation

or center shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates. Not later than July 1, 2008, the Insurance Commissioner shall adopt regulations, in accordance with chapter 54, to implement the provisions of this subsection. Such regulations shall specify the type of nonforfeiture benefit that may be offered, the standards for such benefit, the period of time during which a contingent benefit upon lapse will be available and the substantial increase in premium rates that trigger a contingent benefit upon lapse in accordance with the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners.

(e) The Insurance Commissioner shall adopt regulations, in accordance with chapter 54, **[**which**]** that address (1) the insured's right to information prior to his replacing an accident and sickness policy with a long-term care policy, (2) the insured's right to return a long-term care policy to the insurer, within a specified period of time after delivery, for cancellation, and (3) the insured's right to accept by **[**his**]** the insured's signature, and prior to it becoming effective, any rider or endorsement added to a long-term care policy after the issuance date of such policy. The Insurance Commissioner shall adopt such additional regulations as **[**he**]** the commissioner deems necessary in accordance with chapter 54 to carry out the purpose of this section.

(f) The Insurance Commissioner may, upon written request by any such company, society, corporation or center, issue an order to modify or suspend a specific provision of this section or any regulation adopted pursuant thereto with respect to a specific long-term care policy upon a written finding that: (1) The modification or suspension would be in the best interest of the insureds; (2) the purposes to be achieved could not be effectively or efficiently achieved without such modification or suspension; and (3) (A) the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care, (B) the policy is to be issued to residents of a life care or continuing care retirement community or

other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such community, or (C) the modification or suspension is necessary to permit long-term care policies to be sold as part of, or in conjunction with, another insurance product. **[**, whenever**]** Whenever the commissioner decides not to issue such an order, **[**he**]** the commissioner shall provide written notice of such decision to the requesting party in a timely manner.

(g) Upon written request by any such company, society, corporation or center, the Insurance Commissioner may issue an order to extend the preexisting condition exclusion period, as established by regulations adopted pursuant to this section, for purposes of specific age group categories in a specific long-term care policy form whenever **[**he**]** the commissioner makes a written finding that such an extension is in the best interest to the public. Whenever the commissioner decides not to issue such an order, **[**he**]** the commissioner shall provide written notice of such decision to the requesting party in a timely manner.

(h) The provisions of section 38a-19 shall be applicable to any such requesting party aggrieved by any order or decision of the commissioner made pursuant to subsections (f) and (g) of this section.

Sec. 16. Section 38a-504g of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Any insurer or health care center with coverage policies for care in clinical trials shall submit such policies to the Insurance Department for evaluation and approval. The department shall certify whether the insurer's or health care center's coverage policy for routine patient care costs associated with clinical trials is substantially equivalent to the requirements of sections 38a-504a to **[**38a-504g**]** 38a-504f, inclusive. If the department finds that such coverage is substantially equivalent to the requirements of sections 38a-504a to **[**38a-504g**]** 38a-504f, inclusive,

as amended by this act, the insurer or health care center shall be exempt from the provisions of sections 38a-504a to **[**38a-504g**]** 38a-504f, inclusive.

(b) Any such insurer or health care center shall report annually, in writing, to the department that there have been no changes in the policy as certified by the department. If there has been any change in the policy, the insurer or health care center shall resubmit its policy for certification by the department.

(c) Any insurer or health care center coverage policy found by the department not to be substantially equivalent to the requirements of sections 38a-504a to **[**38a-504g**]** 38a-504f, inclusive, shall abide by the requirements of sections 38a-504a to **[**38a-504g**]** 38a-504f, inclusive, until the insurer or health care center has received such certification by the department.

Sec. 17. Section 38a-542g of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Any insurer or health care center with coverage policies for care in clinical trials shall submit such policies to the Insurance Department for evaluation and approval. The department shall certify whether the insurer's or health care center's coverage policy for routine patient care costs associated with clinical trials is substantially equivalent to the requirements of sections 38a-542a to **[**38a-542g**]** 38a-542f, inclusive, as amended by this act. If the department finds that such coverage is substantially equivalent to the requirements of sections 38a-542a to **[**38a-542g**]** 38a-542f, inclusive, as amended by this act, the insurer or health care center shall be exempt from the provisions of sections 38a-542a to **[**38a-542g**]** 38a-542f, inclusive, as amended by this act.

(b) Any such insurer or health care center shall report annually, in writing, to the department that there have been no changes in the policy as certified by the department. If there has been any change in

the policy, the insurer or health care center shall resubmit its policy for certification by the department.

(c) Any insurer or health care center coverage policy found by the department not to be substantially equivalent to the requirements of sections 38a-542a to **[**38a-542g**]** 38a-542f, inclusive, as amended by this act, shall abide by the requirements of sections 38a-542a to **[**38a-542g**]** 38a-542f, inclusive, as amended by this act, until the insurer or health care center has received such certification by the department.

Sec. 18. Subdivisions (2) and (3) of subsection (b) of section 38a-513f of the 2012 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective from passage*):

(2) Include in such **[**requested**]** information specified in subdivision (1) of this subsection only health information that has had identifiers removed, as set forth in 45 CFR 164.514, is not individually identifiable, as defined in 45 CFR 160.103, and is permitted to be disclosed under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, or regulations adopted thereunder; and

(3) Provide such **[**requested**]** information (A) in a written report, (B) through an electronic file transmitted by secure electronic mail or a file transfer protocol site, or (C) through a secure web site or web site portal that is accessible by such employer.

Sec. 19. Subsection (l) of section 38a-514 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(l) The services rendered for which benefits are to be paid for confinement in a residential treatment facility **[**must**]** shall be based on an individual treatment plan. For purposes of this section, the term "individual treatment plan" means a treatment plan prescribed by a physician with specific attainable goals and objectives appropriate to

both the patient and the treatment modality of the program.

Sec. 20. Subdivision (4) of subsection (a) of section 38a-514b of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(4) "Behavioral therapy" means any interactive behavioral therapies derived from evidence-based research, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with an autism spectrum disorder, that are: (A) Provided to children less than fifteen years of age; **[**,**]** and (B) provided or supervised by (i) a behavior analyst who is certified by the Behavior Analyst Certification Board, (ii) a licensed physician, or (iii) a licensed psychologist. For the purposes of this subdivision, behavioral therapy is "supervised by" such behavior analyst, licensed physician or licensed psychologist when such supervision entails at least one hour of face-to-face supervision of the autism services provider by such behavior analyst, licensed physician or licensed psychologist for each ten hours of behavioral therapy provided by the supervised provider.

Sec. 21. Subdivision (2) of subsection (a) of section 38a-542f of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(2) For purposes of clinical trials other than cancer clinical trials, the Insurance Department, in cooperation with at least one state nonprofit research or advocacy organization concerned with the subject of the clinical trial, at least one national nonprofit research or advocacy organization concerned with the subject of the clinical trial, the Connecticut Association of Health Plans and Anthem Blue Cross of Connecticut, shall develop a standardized form that all providers, hospitals and institutions shall submit to the insurer or health care center when seeking to enroll an insured person in a clinical trial. An insurer or health care center shall not substitute any other approval request form for the form developed by the department, except that

any insurer or health care center that has entered into an agreement to provide coverage for clinical trials approved pursuant to section **[**38a-504g**]** 38a-542g, as amended by this act, may use the form or process established by such agreement.

Sec. 22. Subsection (a) of section 38a-556 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) (1) The board of directors of the association shall be made up of nine individuals selected by participating members, subject to approval by the commissioner, two of whom shall be appointed by the commissioner on or before July 1, 1993, to represent health care centers. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the net health insurance premium derived from this state in the previous calendar year. If the board of directors is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial board. In approving or selecting members of the board, the commissioner may consider, among other things, whether all members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services. (2) The board shall submit to the commissioner a plan of operation for the association necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, must be made available. The commissioner shall, after notice and hearing, approve the plan of operation provided such plan is determined to be suitable to assure the

fair, reasonable and equitable administration of the association, and provides for the sharing of association gains or losses on an equitable proportionate basis. If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, or if at any time thereafter the board fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner. The plan of operation shall, in addition to requirements enumerated in sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive: (A) Establish procedures for the handling and accounting of assets and moneys of the association; (B) establish regular times and places for meetings of the board of directors; (C) establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner; (D) establish procedures whereby selections for the board of directors shall be made and submitted to the commissioner; (E) establish procedures to amend, subject to the approval of the commissioner, the plan of operations; (F) establish procedures for the selection of an administrator and set forth the powers and duties of the administrator; (G) contain additional provisions necessary or proper for the execution of the powers and duties of the association; (H) establish procedures for the advertisement on behalf of all participating carriers of the general availability of the comprehensive coverage under sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive; (I) contain additional provisions necessary for the association to qualify as an acceptable alternative mechanism in accordance with Section 2744 of the Public Health Service Act, as set forth in the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191; and (J) contain additional provisions necessary for the association to qualify as acceptable coverage in accordance with the Pension Benefit Guaranty Corporation and Trade Adjustment Assistance programs of the Trade Act of 2002, P.L. 107-210. The

commissioner may adopt regulations, in accordance with the provisions of chapter 54, to establish criteria for the association to qualify as an acceptable alternative mechanism.

Sec. 23. Section 38a-557 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Hospital service corporations and medical service corporations may elect to meet the obligations of section 38a-552 by participating in the Health Reinsurance Association established in section 38a-556, as amended by this act, as a full member thereof, or by making comprehensive health care plans available directly through a subscriber contract or combination of contracts or by forming a separate residual market mechanism substantially similar to the association established in section 38a-556, as amended by this act.

(b) In the event that hospital service corporations and medical service corporations choose to form a separate residual market mechanism, the commissioner shall have the same regulatory powers over that residual market mechanism as **[**he**]** the commissioner has over the Health Reinsurance Association, and such residual market mechanism shall have the same powers and duties as the association. Rating classifications under a residual market mechanism established under this section need not be the same as classifications established under the association, but any rates established by the residual market mechanism shall be approved by the commissioner. The commissioner shall promulgate regulations to carry out the requirements of this section.

(c) If **[**the**]** hospital service corporations and medical service corporations do not elect to participate in the Health Reinsurance Association, such **[**hospital and medical**]** service corporations shall be required to make an individual comprehensive health care plan available to every resident of this state except residents who are both sixty-five years of age or older and eligible for Medicare and whose coverage under a group or individual contract issued by such **[**hospital

or medical**]** service **[**corporation**]** corporations has terminated. Such coverage may be made available through a separate residual market mechanism established under this section.

Sec. 24. Subdivision (3) of subsection (e) of section 38a-591g of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(3) Not later than **[**(A)**]** five business days after the health carrier receives the copy of an external review request **[**,**]** or **[**(B)**]** one calendar day after the health carrier receives the copy of an expedited external review request, from the commissioner, the health carrier shall complete a preliminary review of the request to determine whether:

(A) The individual is or was a covered person under the health benefit plan at the time the health care service was requested or, in the case of an external review of a retrospective review request, was a covered person in the health benefit plan at the time the health care service was provided;

(B) The health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan but for the health carrier's determination that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

(C) If the health care service or treatment is experimental or investigational:

(i) Is a covered benefit under the covered person's health benefit plan but for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition;

(ii) Is not explicitly listed as an excluded benefit under the covered

person's health benefit plan;

(iii) The covered person's treating health care professional has certified that one of the following situations is applicable:

(I) Standard health care services or treatments have not been effective in improving the medical condition of the covered person;

(II) Standard health care services or treatments are not medically appropriate for the covered person; or

(III) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment; and

(iv) The covered person's treating health care professional:

(I) Has recommended a health care service or treatment that the health care professional certifies, in writing, is likely to be more beneficial to the covered person, in the health care professional's opinion, than any available standard health care services or treatments; or

(II) Is a licensed, board certified or board eligible health care professional qualified to practice in the area of medicine appropriate to treat the covered person's condition and has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or the final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments;

(D) The covered person has exhausted the health carrier's internal grievance process or the covered person or the covered person's authorized representative has filed a request for an expedited external review as provided under subsection (d) of this section; and

(E) The covered person has provided all the information and forms required to process an external review or an expedited external review, including an authorization form as set forth in subparagraph (D)(ii) of subdivision (2) of subsection (c) of this section.

Sec. 25. Subparagraph (A) of subdivision (1) of subsection (c) of section 38a-591*l* of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(A) A quality assurance mechanism in place that ensures:

(i) That external reviews and expedited external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(ii) (I) The selection of qualified and impartial clinical peers to conduct such reviews on behalf of the independent review organization and the suitable matching of such peers to specific cases, and (II) **[**employs or contracts**]** the employment of or the contracting with an adequate number of clinical peers to meet this objective;

(iii) The confidentiality of medical and treatment records and clinical review criteria;

(iv) That any person employed by or under contract with the independent review organization adheres to the requirements of section 38a-591g, as amended by this act; and

Sec. 26. Subsection (a) of section 38a-720*l* of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Each third-party administrator licensed under section 38a-720j shall file an annual report for the preceding calendar year with the commissioner on or before July first of each year or within such extension of time as the commissioner may grant for good cause. The

annual report shall be in the form and contain such information as the commissioner prescribes, including evidence that the surety bond required under subdivision (1) of subsection (a) of **[**this**]** section 38a-720j and, if applicable, subsection (h) of section 38a-720j, remain in force. The information contained in such report shall be verified by at least two officers of the third-party administrator.

Sec. 27. Subsections (a) and (b) of section 38a-743 of the 2012 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Every person, firm, association or corporation licensed pursuant to the provisions of sections 38a-741 to 38a-744, inclusive, as amended by this act, **[**38a-777**]** and 38a-794 shall pay to the commissioner on May first of each year a sum equal to four per cent of the gross premiums charged the insureds by the insurers during the period from January first to March thirty-first of that year, and on August first of each year a sum equal to four per cent of the gross premiums charged the insured by the insurers during the period from April first to June thirtieth of that year, on November first of each year a sum equal to four per cent of the gross premiums charged the insureds by the insurers during the period from July first to September thirtieth of that year and on February first of each year a sum equal to four per cent of the gross premiums charged the insureds by the insurers during the period from October first to December thirty-first of the preceding year, for insurance procured by such licensee pursuant to such license, less the amount of such premiums returned to such insureds, except that the premium tax shall not apply to any policy issued to the state of Connecticut or any agency of the state or to any policy issued to any town, or agency of such town or special taxing district when such town, agency or department thereof or special taxing district appears in the policy as the named insured and as such is responsible for the payment of premiums shown on such policy. Each licensee shall also file on May first, August first, November first, and February first a return, in the form described by the commissioner, showing such

information as the commissioner deems necessary. The provisions of this subsection shall not apply to nonadmitted insurance, as defined in subsection (b) of this section, that is procured, continued or renewed on or after July 1, 2011.

(b) For purposes of this subsection and subsections (c) to (g), inclusive, of this section:

(1) "Home state" means home state, as defined in Section 527 of the Nonadmitted and Reinsurance Reform Act of 2010;

(2) "Licensee" means a person, firm, association or corporation that is licensed pursuant to the provisions of sections 38a-741 to 38a-744, inclusive, as amended by this act, **[**38a-777**]** and 38a-794 and that is a surplus lines broker, as defined in Section 527 of the Nonadmitted and Reinsurance Reform Act of 2010;

(3) "Nonadmitted and Reinsurance Reform Act of 2010" means Sections 511 to 542, inclusive, of the Dodd-Frank Wall Street Reform and Consumer Protection Act, P.L. 111-203, as amended from time to time;

(4) "Nonadmitted insurance" means nonadmitted insurance, as defined in Section 527 of the Nonadmitted and Reinsurance Reform Act of 2010; and

(5) "Nonadmitted insurer" means a nonadmitted insurer, as defined in Section 527 of the Nonadmitted and Reinsurance Reform Act of 2010.

Sec. 28. Section 38a-744 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Any licensee acting in conformance with sections 38a-741 to 38a-744, inclusive, as amended by this act, **[**38a-777**]** and 38a-794 shall not be subject to personal liability as set forth in section 38a-714.

Sec. 29. Section 38a-745 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Each insurance policy issued pursuant to sections 38a-741 to 38a-744, inclusive, as amended by this act, **[**38a-777**]** and 38a-794 by a surplus lines insurer shall bear on its cover, in not less than twelve-point boldface type in capital letters, the following:

NOTICE

THIS IS A SURPLUS LINES POLICY AND IS NOT PROTECTED BY THE CONNECTICUT INSURANCE GUARANTY ASSOCIATION.

Sec. 30. Section 38a-770 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Whenever the Insurance Commissioner receives an application for an initial license or license renewal, pursuant to the requirements of sections 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to **[**38a-745**]** 38a-744, inclusive, as amended by this act, 38a-769, 38a-771 to **[**38a-777**]** 38a-776, inclusive, as amended by this act, 38a-786, 38a-790, 38a-792 and 38a-794, which is not accompanied by the required fees, the commissioner shall return such application together with all accompanying fees, unless the commissioner, at the commissioner's discretion, chooses to invoice any such fees not submitted with the initial or renewal applications. Whenever the Insurance Commissioner receives an application accompanied by the required fees accepted by the commissioner, all examination and filing fees are deemed earned.

Sec. 31. Subsection (a) of section 38a-771 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Any person, firm, partnership, association or corporation holding a license issued pursuant to sections 38a-702j, 38a-703 to 38a-716, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to 38a-745,

inclusive, as amended by this act, 38a-769 to [38a-777] 38a-776, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794 or holding a license in the name of a trade name shall notify the Insurance Commissioner, in writing, not later than thirty days after any: (1) Change in business or residence address; (2) change in employer; (3) change in name; or (4) change in licensed members of a firm, partnership, association or officers of a corporation as stated in the application for license.

Sec. 32. Section 38a-772 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Any person wilfully misrepresenting any fact required to be disclosed in any application or in any other form, paper or document required to be filed with the commissioner in connection with an application for any license issued by the commissioner pursuant to sections 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to 38a-745, inclusive, as amended by this act, 38a-769 to [38a-777] 38a-776, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794 shall be fined not more than four thousand dollars or imprisoned not more than six months, or both.

Sec. 33. Section 38a-760 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Sections 38a-760 to [38a-760i] 38a-760j, inclusive, as amended by this act, may be cited as the "Reinsurance Intermediary Act".

Sec. 34. Section 38a-760a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

As used in sections 38a-760 to [38a-760i] 38a-760j, inclusive, as amended by this act:

(1) "Actuary" means a person who is a member in good standing of the American Academy of Actuaries;

(2) "Controlling person" means any person, firm, association or

corporation who directly or indirectly has the power to direct or cause to be directed, the management, control or activities of the reinsurance intermediary;

(3) "Insurer" means any person, firm, association or corporation duly licensed in this state pursuant to section 38a-41;

(4) "Licensed producer" means an agent or broker licensed pursuant to sections 38a-769 to 38a-800, inclusive, or licensed as a reinsurance intermediary pursuant to section 38a-760b;

(5) "Reinsurance intermediary" means a reinsurance intermediary-broker or a reinsurance intermediary-manager as these terms are defined in subdivisions (6) and (7) of this section;

(6) "Reinsurance intermediary-broker" means any person, other than an officer or employee of the ceding insurer, or firm, association or corporation, who solicits, negotiates or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of such insurer;

(7) "Reinsurance intermediary-manager" means any person, firm, association or corporation who has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department or underwriting office, and acts as an agent for such reinsurer whether known as a reinsurance intermediary-manager, manager or other similar term. Notwithstanding any provision of the general statutes, the following persons shall not be considered a reinsurance intermediary-manager, with respect to such reinsurer, for the purposes of sections 38a-760 to 38a-760i, inclusive, as amended by this act: (A) An employee of the reinsurer; (B) a United States manager of the United States branch of an alien reinsurer; (C) an underwriting manager that, pursuant to contract, manages all or part of the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to sections 38a-129 to 38a-140, inclusive, and whose compensation is not

based on the volume of premiums written; (D) the manager of a group, association, pool or organization of insurers that engages in joint underwriting or joint reinsurance and that is subject to examination by the insurance commissioner of the state in which the manager's principal business office is located;

(8) "Reinsurer" means any person, firm, association or corporation duly licensed in this state pursuant to the applicable provisions of this title as an insurer with the authority to assume reinsurance;

(9) "To be in violation" means that the reinsurance intermediary, or the insurer or reinsurer for whom the reinsurance intermediary was acting, failed to substantially comply with the provisions of sections 38a-760 to 38a-760i, inclusive, as amended by this act;

(10) "Qualified United States Financial Institutions" means **[**, for purposes of sections 38a-760 to 38a-760i, inclusive,**]** an institution that:

(A) Is organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state thereof;

(B) Is regulated, supervised and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(C) Has been determined by either the commissioner or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

Sec. 35. Subsection (e) of section 38a-760j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(e) Nothing contained in sections 38a-760 to **[**38a-760i**]** 38a-760j, inclusive, as amended by this act, is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, creditors or other third parties.

Sec. 36. Subdivision (1) of section 38a-816 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(1) Misrepresentations and false advertising of insurance policies. Making, issuing or circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement, sales presentation, omission or comparison which: **[**(a)**]** (A) Misrepresents the benefits, advantages, conditions or terms of any insurance policy; **[**(b)**]** (B) misrepresents the dividends or share of the surplus to be received, on any insurance policy; **[**(c)**]** (C) makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy; **[**(d)**]** (D) is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates; **[**(e)**]** (E) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; **[**(f)**]** (F) is a misrepresentation, including, but not limited to, an intentional misquote of a premium rate, for the purpose of inducing or tending to induce to the purchase, lapse, forfeiture, exchange, conversion or surrender of any insurance policy; **[**(g)**]** (G) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or **[**(h)**]** (H) misrepresents any insurance policy as being shares of stock.

Sec. 37. Subdivision (6) of section 38a-816 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(6) Unfair claim settlement practices. Committing or performing with such frequency as to indicate a general business practice any of

the following: [(a)] (A) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue; [(b)] (B) failing to acknowledge and act with reasonable promptness upon communications with respect to claims arising under insurance policies; [(c)] (C) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; [(d)] (D) refusing to pay claims without conducting a reasonable investigation based upon all available information; [(e)] (E) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed; [(f)] (F) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear; [(g)] (G) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds; [(h)] (H) attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application; [(i)] (I) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured; [(j)] (J) making claims payments to insureds or beneficiaries not accompanied by statements setting forth the coverage under which the payments are being made; [(k)] (K) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration; [(l)] (L) delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information; [(m)] (M) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy

coverage; **[**(n)**]** (N) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; **[**(o)**]** (O) using as a basis for cash settlement with a first party automobile insurance claimant an amount which is less than the amount which the insurer would pay if repairs were made unless such amount is agreed to by the insured or provided for by the insurance policy.

Sec. 38. Subdivision (9) of section 38a-816 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(9) Any violation of any one of sections 38a-358, 38a-446, 38a-447, 38a-488, 38a-825, 38a-826, 38a-828 and 38a-829. None of the following practices shall be considered discrimination within the meaning of section 38a-446 or 38a-488 or a rebate within the meaning of section 38a-825: **[**(a)**]** (A) Paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders; **[**(b)**]** (B) in the case of policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense; **[**(c)**]** (C) readjustment of the rate of premium for a group insurance policy based on loss or expense experience, or both, at the end of the first or any subsequent policy year, which may be made retroactive for such policy year.

Sec. 39. Subdivision (11) of section 38a-816 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(11) Favored agent or insurer: Coercion of debtors. **[**(a)**]** (A) No

person may (i) require, as a condition precedent to the lending of money or extension of credit, or any renewal thereof, that the person to whom such money or credit is extended or whose obligation the creditor is to acquire or finance, negotiate any policy or contract of insurance through a particular insurer or group of insurers or producer or group of producers; (ii) unreasonably disapprove the insurance policy provided by a borrower for the protection of the property securing the credit or lien; (iii) require directly or indirectly that any borrower, mortgagor, purchaser, insurer or producer pay a separate charge, in connection with the handling of any insurance policy required as security for a loan on real estate or pay a separate charge to substitute the insurance policy of one insurer for that of another; or (iv) use or disclose information resulting from a requirement that a borrower, mortgagor or purchaser furnish insurance of any kind on real property being conveyed or used as collateral security to a loan, when such information is to the advantage of the mortgagee, vendor or lender, or is to the detriment of the borrower, mortgagor, purchaser, insurer or the producer complying with such a requirement.

[(b)**]** (B) (i) **[**Subsection (a)(iii) does**]** Subparagraph (A)(iii) of this subdivision shall not include the interest which may be charged on premium loans or premium advancements in accordance with the security instrument. (ii) For purposes of **[**subsection (a)(ii)**]** subparagraph (A)(ii) of this subdivision, such disapproval shall be deemed unreasonable if it is not based solely on reasonable standards uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, nor shall such standards call for the disapproval of an insurance policy because such policy contains coverage in addition to that required. (iii) The commissioner may investigate the affairs of any person to whom this **[**subsection**]** subdivision applies to determine whether such person has violated this **[**subsection**]** subdivision. If a violation of this **[**subsection**]** subdivision is found, the person in violation shall be subject to the

same procedures and penalties as are applicable to other provisions of section 38a-815, subsections (b) and (e) of section 38a-817 and this section. (iv) For purposes of this section, "person" includes any individual, corporation, limited liability company, association, partnership or other legal entity.

Sec. 40. Subsection (b) of section 38a-1010 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) An actuarial opinion regarding reserves for: (1) Known claims and any associated expenses; and (2) claims incurred but not reported and any associated expenses shall be included in the audited financial statement. The actuarial opinion shall be prepared **[**(i)**]** (A) by an independent person with a designation of Fellow of the Casualty Actuarial Society (FCAS), **[**(ii)**]** (B) by a member of the American Academy of Actuaries (MAAA) with experience in preparing such opinions, or **[**(iii)**]** (C) by any other qualified loss reserve specialist in accordance with the provisions of section 38a-14.

Sec. 41. Section 38a-478i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

No contract delivered, issued for delivery, renewed, amended or continued in this state **[**on and after October 1, 1997,**]** between a managed care organization and a participating provider shall prohibit or limit any cause of action or contract rights an enrollee otherwise has.

Sec. 42. Section 38a-478k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) No contract delivered, issued for delivery, renewed, amended or continued in this state **[**on and after October 1, 1997,**]** between a managed care organization and a participating provider shall prohibit the provider from discussing with an enrollee any treatment options and services available in or out of network, including experimental

treatments.

(b) No contract delivered, issued for delivery, renewed, amended or continued in this state **[**on and after October 1, 1997,**]** between a managed care organization and a participating provider shall prohibit the provider from disclosing, to an enrollee who inquires, the method the managed care organization uses to compensate the provider.

Sec. 43. Subsection (a) of section 38a-483c of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Each individual health insurance policy delivered, issued for delivery, renewed, amended or continued in this state **[**on or after January 1, 2000,**]** shall define the extent to which it provides coverage for experimental treatments.

Sec. 44. Subsection (a) of section 38a-513b of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Each group health insurance policy delivered, issued for delivery, renewed, amended or continued in this state **[**on or after January 1, 2000,**]** shall define the extent to which it provides coverage for experimental treatments.

Sec. 45. Subsection (a) of section 38a-488a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state **[**on or after January 1, 2000,**]** shall provide benefits for the diagnosis and treatment of mental or nervous conditions. For the purposes of this section, "mental or nervous conditions" means mental disorders, as defined in the most recent edition of the American

Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". "Mental or nervous conditions" does not include (1) mental retardation, (2) learning disorders, (3) motor skills disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

Sec. 46. Subsection (a) of section 38a-514 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Except as provided in subsection (j) of this section, each group health insurance policy, providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state **[**on or after January 1, 2000,**]** shall provide benefits for the diagnosis and treatment of mental or nervous conditions. For the purposes of this section, "mental or nervous conditions" means mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". "Mental or nervous conditions" does not include (1) mental retardation, (2) learning disorders, (3) motor skills disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

Sec. 47. Section 38a-490b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in

this state **[**on or after October 1, 2001,**]** shall provide coverage for hearing aids for children twelve years of age or younger. Such hearing aids shall be considered durable medical equipment under the policy and the policy may limit the hearing aid benefit to one thousand dollars within a twenty-four-month period.

Sec. 48. Section 38a-516b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state **[**on or after October 1, 2001,**]** shall provide coverage for hearing aids for children twelve years of age or younger. Such hearing aids shall be considered durable medical equipment under the policy and the policy may limit the hearing aid benefit to one thousand dollars within a twenty-four-month period.

Sec. 49. Section 38a-498b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Each individual health insurance policy providing coverage of the type specified in subdivisions (1) to (13), inclusive, of section 38a-469 delivered, issued for delivery, renewed, amended or continued in **[**the**]** this state **[**on or after July 1, 2005,**]** shall provide benefits for isolation care and emergency services provided by the state's mobile field hospital. Such benefits shall be subject to any policy provisions that apply to other services covered by such policy. The rates paid by individual health insurance policies pursuant to this section shall be equal to the rates paid under the Medicaid program, as determined by the Department of Social Services.

Sec. 50. Section 38a-525b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Each group health insurance policy providing coverage of the type

specified in subdivisions (1) to (13), inclusive, of section 38a-469 delivered, issued for delivery, renewed, amended or continued in **[**the**]** this state **[**on or after July 1, 2005,**]** shall provide benefits for isolation care and emergency services provided by the state's mobile field hospital. Such benefits shall be subject to any policy provisions that apply to other services covered by such policy. The rates paid by group health insurance policies pursuant to this section shall be equal to the rates paid under the Medicaid program, as determined by the Department of Social Services.

Sec. 51. Section 38a-498c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

No individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state **[**on or after October 1, 2006,**]** shall deny coverage for health care services rendered to treat any injury sustained by any person when such injury is alleged to have occurred or occurs under circumstances in which (1) such person has an elevated blood alcohol content, or (2) such person has sustained such injury while under the influence of intoxicating liquor or any drug or both. For the purposes of this section, "elevated blood alcohol content" means a ratio of alcohol in the blood of such person that is eight-hundredths of one per cent or more of alcohol, by weight.

Sec. 52. Section 38a-525c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state **[**on or after October 1, 2006,**]** shall deny coverage for health care services rendered to treat any injury sustained by any person when such injury is alleged to have occurred or occurs under circumstances in which (1) such person has an elevated blood alcohol content, or (2)

such person has sustained such injury while under the influence of intoxicating liquor or any drug or both. For the purposes of this section, "elevated blood alcohol content" means a ratio of alcohol in the blood of such person that is eight-hundredths of one per cent or more of alcohol, by weight.

Sec. 53. Subsection (a) of section 38a-474 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2013*):

(a) **[**On and after October 1, 1990, any**]** Any insurance company, fraternal benefit society, hospital service corporation, **[**or**]** medical service corporation, **[**and on and after January 1, 1994, any**]** health care center or other entity which delivers, issues for delivery, **[**continues or**]** renews, amends or continues in this state any Medicare supplement policy or certificate, as defined in sections 38a-495, 38a-495a and 38a-522, seeking to change its rates shall file a request for such change with the Insurance Department at least sixty days prior to the proposed effective date of such change. The Insurance Department shall review the request and, with respect to requests for an increase in rates, shall hold a public hearing on such increase. The Insurance Commissioner shall approve or deny the request not later than forty-five days after its receipt. The Insurance Commissioner shall adopt regulations, in accordance with chapter 54, to set requirements for the submission of data pertaining to a request to change rates and to define the policies utilized in making a decision on such change in rates.

Sec. 54. Subsections (b) and (c) of section 38a-492c of the general statutes are repealed and the following is substituted in lieu thereof (*Effective January 1, 2013*):

(b) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), **[**(6),**]** (11) and (12) of section 38a-469 delivered, issued for delivery, **[**or**]** renewed, amended or continued in this state **[**on or after October 1, 1997,**]** shall provide coverage for amino acid modified preparations and low protein

modified food products for the treatment of inherited metabolic diseases if the amino acid modified preparations or low protein modified food products are prescribed for the therapeutic treatment of inherited metabolic diseases and are administered under the direction of a physician.

(c) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), **[**(6),**]** (11) and (12) of section 38a-469 delivered, issued for delivery, **[**or**]** renewed, amended or continued in this state **[**on or after October 1, 2007,**]** shall provide coverage for specialized formulas when such specialized formulas are medically necessary for the treatment of a disease or condition and are administered under the direction of a physician.

Sec. 55. Subsections (b) and (c) of section 38a-518c of the general statutes are repealed and the following is substituted in lieu thereof (*Effective January 1, 2013*):

(b) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), **[**(6),**]** (11) and (12) of section 38a-469 delivered, issued for delivery, **[**or**]** renewed, amended or continued in this state **[**on or after October 1, 1997,**]** shall provide coverage for amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases if the amino acid modified preparations or low protein modified food products are prescribed for the therapeutic treatment of inherited metabolic diseases and are administered under the direction of a physician.

(c) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), **[**(6),**]** (11) and (12) of section 38a-469 delivered, issued for delivery, **[**or**]** renewed, amended or continued in this state **[**on or after October 1, 2007,**]** shall provide coverage for specialized formulas when such specialized formulas are medically necessary for the treatment of a disease or condition and are administered under the direction of a physician.

Sec. 56. Section 38a-492f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2013*):

Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state **[**on or after January 1, 2000,**]** that provides coverage for outpatient prescription drugs shall not deny coverage for an insured for any drug that the insurer removes from its list of covered drugs, or otherwise ceases to provide coverage for, if (1) the insured was using the drug for the treatment of a chronic illness prior to the removal or cessation of coverage, (2) the insured was covered under the policy for the drug prior to the removal or cessation of coverage, and (3) the insured's attending health care provider states in writing, after the removal or cessation of coverage, that the drug is medically necessary and lists the reasons why the drug is more medically beneficial than the drugs on the list of covered drugs. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies.

Sec. 57. Section 38a-518f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2013*):

Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state **[**on or after January 1, 2000,**]** that provides coverage for outpatient prescription drugs shall not deny coverage for an insured for any drug that the insurer removes from its list of covered drugs, or otherwise ceases to provide coverage for, if (1) the insured was using the drug for the treatment of a chronic illness prior to the removal or cessation of coverage, (2) the insured was covered under the policy for the drug prior to the removal or cessation of coverage, and (3) the insured's attending health care provider states in writing, after the removal or cessation of coverage, that the drug is medically necessary

and lists the reasons why the drug is more medically beneficial than the drugs on the list of covered drugs. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies.

Sec. 58. Subsection (a) of section 38a-498 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2013*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, **[**or**]** amended or continued in this state **[**on or after October 1, 2002,**]** shall provide coverage for medically necessary ambulance services for persons covered by the policy. The hospital policy shall be primary if a person is covered under more than one policy. The policy shall, as a minimum requirement, cover such services whenever any person covered by the contract is transported when medically necessary by ambulance to a hospital. Such benefits shall be subject to any policy provision which applies to other services covered by such policies. Notwithstanding any other provision of this section, such policies shall not be required to provide benefits in excess of the maximum allowable rate established by the Department of Public Health in accordance with section 19a-177.

Sec. 59. Subsection (a) of section 38a-525 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2013*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, **[**or**]** amended or continued in this state **[**on or after October 1, 2002,**]** shall provide coverage for medically necessary ambulance services for persons covered by the policy. The hospital policy shall be primary if a person is covered under more than one policy. The policy shall, as a minimum

requirement, cover such services whenever any person covered by the contract is transported when medically necessary by ambulance to a hospital. Such benefits shall be subject to any policy provision which applies to other services covered by such policies. Notwithstanding any other provision of this section, such policies shall not be required to provide benefits in excess of the maximum allowable rate established by the Department of Public Health in accordance with section 19a-177.

Sec. 60. Section 38a-471 of the general statutes is repealed. (*Effective from passage*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	38a-15(b) and (c)
Sec. 2	*from passage*	38a-91bb(a)(5)
Sec. 3	*from passage*	38a-155(g)
Sec. 4	*from passage*	38a-188
Sec. 5	*from passage*	38a-271(b)
Sec. 6	*from passage*	38a-323(f)
Sec. 7	*from passage*	38a-324(b)
Sec. 8	*from passage*	38a-364(b)
Sec. 9	*from passage*	38a-472h(a)
Sec. 10	*from passage*	38a-478g(b)(3)
Sec. 11	*from passage*	38a-481(d)
Sec. 12	*from passage*	38a-490(a)
Sec. 13	*from passage*	38a-516(a)
Sec. 14	*from passage*	38a-495c
Sec. 15	*from passage*	38a-501
Sec. 16	*from passage*	38a-504g
Sec. 17	*from passage*	38a-542g
Sec. 18	*from passage*	38a-513f(b)(2) and (3)
Sec. 19	*from passage*	38a-514(l)
Sec. 20	*from passage*	38a-514b(a)(4)
Sec. 21	*from passage*	38a-542f(a)(2)
Sec. 22	*from passage*	38a-556(a)
Sec. 23	*from passage*	38a-557
Sec. 24	*from passage*	38a-591g(e)(3)

Sec. 25	*from passage*	38a-591l(c)(1)(A)
Sec. 26	*from passage*	38a-720l(a)
Sec. 27	*from passage*	38a-743(a) and (b)
Sec. 28	*from passage*	38a-744
Sec. 29	*from passage*	38a-745
Sec. 30	*from passage*	38a-770
Sec. 31	*from passage*	38a-771(a)
Sec. 32	*from passage*	38a-772
Sec. 33	*from passage*	38a-760
Sec. 34	*from passage*	38a-760a
Sec. 35	*from passage*	38a-760j(e)
Sec. 36	*from passage*	38a-816(1)
Sec. 37	*from passage*	38a-816(6)
Sec. 38	*from passage*	38a-816(9)
Sec. 39	*from passage*	38a-816(11)
Sec. 40	*from passage*	38a-1010(b)
Sec. 41	*from passage*	38a-478i
Sec. 42	*from passage*	38a-478k
Sec. 43	*from passage*	38a-483c(a)
Sec. 44	*from passage*	38a-513b(a)
Sec. 45	*from passage*	38a-488a(a)
Sec. 46	*from passage*	38a-514(a)
Sec. 47	*from passage*	38a-490b
Sec. 48	*from passage*	38a-516b
Sec. 49	*from passage*	38a-498b
Sec. 50	*from passage*	38a-525b
Sec. 51	*from passage*	38a-498c
Sec. 52	*from passage*	38a-525c
Sec. 53	*January 1, 2013*	38a-474(a)
Sec. 54	*January 1, 2013*	38a-492c(b) and (c)
Sec. 55	*January 1, 2013*	38a-518c(b) and (c)
Sec. 56	*January 1, 2013*	38a-492f
Sec. 57	*January 1, 2013*	38a-518f
Sec. 58	*January 1, 2013*	38a-498(a)
Sec. 59	*January 1, 2013*	38a-525(a)
Sec. 60	*from passage*	Repealer section

Statement of Purpose:

To make technical, conforming and minor changes to the insurance statutes.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]